Glens Falls Vision Care
357 Bay Road., Suite 6
Queensbury, NY 12804
518-792-3304
glensfallsvisioncare.com

- **Your insurance is a contract between you and your insurance company.** You are ultimately responsible for payment regardless of your insurance's arbitrary determination of usual and customary fees.
- **A 50% deposit is required for all eyeglass and contact lens orders.** If your insurance company ***does*** cover hardware, our billing department will forward charges for you. However, you are responsible for any non-covered items and any difference in fees above and beyond your insurance company's allowable amount.
- **All eyeglass lenses are custom made.** Cancelled orders will be subject to a ***30%*** cancellation/restocking fee.
- **Insurance claims are not backdated.** All services and orders are billed on appointment date.
- **Knowledge of benefits and eligibility is your responsibility.** All insurance plans are unique; our staff may not have all the information specific to your plan available to them before your visit.
- **All co-pays are due at the time of service.** If ***not*** paid, a $10.00 service fee will be applied to your account.
- **An Adult is required to accompany all children under the age of 18.** The adult accompanying the minor is responsible for payment of services regard less of the relationship or financial arrangement.
- **We have the right to dismiss a patient at anytime from the practice.** Without notice we reserve the right to terminate our relationship to you at anytime without notice or reason.
- **If you *No Show* for an appointment.** If you do not show for 3 appointments in a row you will no longer be seen at this office.

By signing below I authorize:

-This form to serve as Lifetime Signature on File for my account.

-I have read/ or understood the Notice of Privacy Practices and I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law in the circumstances described in the Notice of Privacy Practices.

Patient Signature _____ Date:_____/_____/_____
(Parent or Guardian)